

§ 488.3 Conditions of participation; conditions for coverage; and long-term care requirements.

(a) *Basic rules.* In order to be approved for participation in or coverage under the Medicare program, a prospective provider or supplier must:

(1) Meet the applicable statutory definition in section 1138(b), 1819, 1832(a)(2)(F), 1861, 1881, or 1919 of the Act; and

(2) Be in compliance with the applicable conditions or long-term care requirements prescribed in subpart N, Q or U of part 405, part 416, subpart C of part 418, part 482, part 483, part 484, part 485, subpart A of part 491, or part 494 of this chapter.

(b) *Special Conditions.* (1) The Secretary, after consultation with the JCAHO or AOA, may issue conditions of participation for hospitals higher or more precise than those of either those accrediting bodies.

(2) The Secretary may, at a State's request, approve health and safety requirements for providers and suppliers in that State, which are higher than those otherwise applied in the Medicare program.

(3) If a State or political subdivision imposes higher requirements on institutions as a condition for the purchase of health services under a State Medicaid Plan approved under Title XIX of the Act, (or if Guam, Puerto Rico, or the Virgin Islands does so under a State plan for Old Age Assistance under Title I of the Act, or for Aid to the Aged, Blind, and Disabled under the original Title XVI of the Act), the Secretary is required to impose similar requirements as a condition for payment under Medicare in that State or political subdivision.

[53 FR 22859, June 17, 1988, as amended at 58 FR 61838, Nov. 23, 1993]

§ 488.4 Application and reapplication procedures for accreditation organizations.

(a) A national accreditation organization applying for approval of deeming authority for Medicare requirements under § 488.5 or 488.6 of this subpart must furnish to CMS the information and materials specified in paragraphs (a)(1) through (10) of this section. A national accreditation organi-

zation reapplying for approval must furnish to CMS whatever information and materials from paragraphs (a)(1) through (10) of this section that CMS requests. The materials and information are—

(1) The types of providers and suppliers for which the organization is requesting approval;

(2) A detailed comparison of the organization's accreditation requirements and standards with the applicable Medicare requirements (for example, a crosswalk);

(3) A detailed description of the organization's survey process, including—

(i) Frequency of the surveys performed;

(ii) Copies of the organization's survey forms, guidelines and instructions to surveyors;

(iii) Accreditation survey review process and the accreditation status decision-making process;

(iv) Procedures used to notify accredited facilities of deficiencies and the procedures used to monitor the correction of deficiencies in accredited facilities; and

(v) Whether surveys are announced or unannounced;

(4) Detailed information about the individuals who perform surveys for the accreditation organization, including—

(i) The size and composition of accreditation survey teams for each type of provider and supplier accredited;

(ii) The education and experience requirements surveyors must meet;

(iii) The content and frequency of the in-service training provided to survey personnel;

(iv) The evaluation systems used to monitor the performance of individual surveyors and survey teams; and

(v) Policies and procedures with respect to an individual's participation in the survey or accreditation decision process of any facility with which the individual is professionally or financially affiliated;

(5) A description of the organization's data management and analysis system with respect to its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system;

(6) The organization's procedures for responding to and for the investigation